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DEFENSE HEALTH CARE

Obstacles in Implementing Coordinated Care

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SUMMARY

Challenges which the Department of Defense (DOD) faces in restructuring its health care system to managed care include: (1) significant budget constraints as the size of the military forces is reduced, (2) building a consensus of support among various parties for managed care, and (3) making key operational decisions in the face of little data from the Department's demonstration projects.

GAO believes that DOD should reconsider certain features of its Coordinated Care program to address the following problems:

-- differences in cost-sharing by enrollees depending on whether they are directed to military facilities or private network providers for their medical care,

-- higher levels of cost-sharing by enrollees compared to those in health maintenance organizations, and

-- use of negative incentives to encourage enrollment such as eliminating nonenrollees access to military health facilities.

GAO believes that DOD should reconsider the range of beneficiary cost-sharing options available for Coordinated Care including (1) instituting small charges for care provided to beneficiaries in military facilities and (2) a system of beneficiary premiums. DOD should postpone its plans to "lock out" nonenrollees from military health care facilities.

At this time, DOD is unprepared to perform some required administrative functions for Coordinated Care. These include: (1) verifying beneficiary eligibility and accurately paying claims, (2) measuring performance of hospital commanders and the overall system, and (3) accurately and equitably budgeting and allocating resources among military hospitals.

Another matter that is engendering much debate is whether DOD should adopt the CHAMPUS Reform Initiative model and contract for health care services, or whether it should administer and provide care directly which is analogous to the Catchment Area Management projects. GAO believes that neither approach should be exclusively used but rather that both approaches should be blended.

Madam Chairman and Members of the Subcommittee:

We are pleased to be here again to discuss military health care issues and, specifically, the Department of Defense (DOD) plan for adopting its Coordinated Care Program throughout the military health services system. Madam Chairman, at your request and others', for about 5 years we have reported and testified on various aspects of the Department's managed health care demonstrations, such as the CHAMPUS[1] Reform Initiative (CRI) and Catchment Area Management (CAM) projects, which have led up to the Coordinated Care Program (see app. I). Details of the Coordinated Care Program are still evolving and the full extent of the proposed changes is not yet known. DOD expects the program to be implemented over the next 3 years, and it is during this period that many of the particulars will become known.

DOD's managed care initiative holds promise and offers the potential for gaining more control over costs and improving beneficiary access while maintaining high-quality care. The program's success, however will depend largely on how well it is implemented, and several significant implementation problems have developed that need to be resolved quickly. My testimony today will focus on (1) the challenges DOD faces in implementing Coordinated Care, (2) implementation problems and some options available to DOD in dealing with them, and (3) the use of contracting in Coordinated Care.

CHALLENGES FACING DOD

DOD faces significant challenges as it tries to restructure its health care system. First, military health care faces budgetary constraints brought about by the anticipated reductions in the size of the military forces. Meeting people's health care needs in the face of budget constraints is a job that the nation as a whole is struggling with. In several respects, DOD is facing the same challenge. These budgetary constraints also impact on how DOD designs the health care benefits it will provide beneficiaries under Coordinated Care.

Second is the challenge of building a consensus for the restructuring changes DOD is pursuing. If it is to succeed, the program needs the support of beneficiaries, military hospital commanders and staff, and the Congress. Garnering this support will not be easy, and at this point I would say that support is lacking among the beneficiary population and it is mixed elsewhere. I will discuss some of the reasons for this momentarily.

Third, there are little reliable data upon which to base decisions or form opinions on key operational aspects of the program. Evaluations of the Department's demonstration programs are not expected to be completed for some time, and the

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[1]Civilian Health and Medical Program of the Uniformed Services.

congressionally mandated comprehensive study and report on the military health care system is not due until December 1993. This lack of information creates the potential for bad decisionmaking.

IMPLEMENTATION PROBLEMS

Now, I would like to address what we view as the most significant implementation issues that the Department needs to address, namely: (1) program features, such as beneficiary cost sharing and incentives to participate, and (2) administrative concerns, such as those with the data systems needed to support key program elements and budgeting and resource allocation systems.

Program Features

Under the Coordinated Care program, DOD has created inequities in cost sharing within specific categories of beneficiaries. It has also imposed some costs on beneficiaries that are not normally associated with managed care health programs, and it has used what beneficiaries and others perceive as negative incentives to induce their participation. These features are very unpopular among the military beneficiary population--to the extent that the program's success is in jeopardy before it has really begun. We believe that DOD has other program feature options available that it should consider that could probably meet budgetary constraints without losing beneficiary support.

Beneficiary Cost Sharing

As you know, under Coordinated Care, beneficiaries who enroll in the program will be directed by a "gatekeeper" to health care providers rather than being able to choose providers themselves as they would under the standard CHAMPUS program. Individuals who are directed to civilian providers will have to pay significantly more for their care than those who can gain access to a military facility.

To illustrate, military retirees, and their dependents or survivors, who enroll in Coordinated Care and are directed to civilian sources of care will pay the annual CHAMPUS deductibles for outpatient care ($150 per person and $300 per family) and copayments of 25 percent for both inpatient and outpatient care. In contrast, those who obtain care in a military hospital or clinic will pay nothing for outpatient care and the current fee of less than $10 per day for inpatient care.

Similarly, dependents of active duty members enrolled in Coordinated Care will pay a deductible and 20 percent of the outpatient costs if they are assigned a civilian provider but will pay nothing if they obtain outpatient care in a military facility. (Inpatient cost sharing for active duty dependents is the same--

less than $10 per day for care provided in both military and civilian hospitals.)

Not only will these cost-sharing features create confusion and inequity among DOD beneficiaries around the country, but they are uncommon among managed health care programs in existence today. For example, instead of outpatient deductibles and percentage copayments, health maintenance organizations (HMOs) generally charge a fee of about $5 per office visit. For inpatient services, some HMOs assess a fee for each admission or for a certain number of days of inpatient services. Seldom do they require enrollees to pay a certain percentage of the cost for entire hospital stays.

Military beneficiary groups correctly point out that HMOs offer reduced cost sharing to their members, particularly compared to traditional fee-for-service health care plans, such as CHAMPUS. Therefore, the DOD beneficiary groups believe that DOD should do the same.

We believe that DOD should consider several alternatives to its current program feature design that could achieve greater equity among enrolled beneficiaries and at the same time establish cost sharing arrangements more similar to HMOs. For example, it could institute a system of small outpatient fees and fees for each inpatient admission to its various categories of enrolled beneficiaries[2] for care provided in both military and civilian facilities. Non-enrollees could be required to pay higher amounts as more traditional fee-for-service type cost sharing.

Another option would be for DOD to introduce a system of nominal beneficiary premiums--a feature that is almost universal in the private sector and other government programs--in lieu of charging enrolled beneficiaries for both outpatient and inpatient services, regardless of whether beneficiaries are directed to military or civilian providers. Nonenrolled beneficiaries would also pay these premiums but continue to be subject to the copayment and deductible requirements of the current CHAMPUS program.

The range of beneficiary cost-sharing options for the new Coordinated Care Program is quite broad and includes others that we have not mentioned today. In view of the widespread dissatisfaction of beneficiaries with the current design, alternatives appear worthy of DOD's further analysis and reconsideration.

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[2]Dependents of active duty members, retirees and their dependents, and survivors.

Beneficiary Incentives to Participate

It is generally recognized that for a managed care program to succeed, it must enroll a significant proportion of a beneficiary population. To encourage people to participate in its Coordinated Care Program, DOD specifies that beneficiaries who choose not to enroll will be denied access to care in a military facility except in emergencies or when obtaining prescription medications. These people will have to use the CHAMPUS program and face higher than the current CHAMPUS deductibles.

Not surprisingly, beneficiaries and the military services view this program feature as an unnecessary and negative way to induce people to enroll. Both groups point to the positive incentives used in the CRI and CAM managed health care demonstration projects as evidence that enough people will enroll to have a beneficial impact on health care delivery, utilization, and costs.

These "positive" incentives include reduced beneficiary cost sharing, achieved primarily by waiving deductibles or reducing copayments. Neither the CRI nor the CAM projects prohibit beneficiaries from receiving care at a military facility if they choose not to enroll in the program. Also, to achieve some cost savings for those who choose not to enroll, nonenrollees are offered discounts if they use network providers for their care. While there are no specific data indicating the precise impact that positive incentives have had on the DOD demonstration projects, over time, enrollment has increased in each. This suggests that as the programs developed and began to mature, they received favorable responses from the beneficiary population, who in turn enrolled in greater numbers.

We believe DOD should, along with adjusting its program feature design as we discussed earlier, postpone its plans to "lock out" nonenrollees from military health care facilities. This would give voluntary enrollment a chance to succeed. If it does not, DOD could reinstitute its "lock out" plan for nonenrolled beneficiaries.

Administrative Functions

DOD's ability to successfully implement Coordinated Care depends on having the necessary administrative infrastructure and systems operating before it begins to deliver care under the new approach. At this time, however, the Department cannot perform some of the required support tasks, such as storing and retrieving the enrollment information needed to verify beneficiary eligibility and pay claims accurately. Other administrative systems requiring further development include a way to measure or evaluate the performance of hospital commanders as well as the system overall, and ways to accurately budget and allocate resources among military hospitals.

Information Systems

Service officials with whom we spoke universally identified information system problems as the most significant Coordinated Care implementation hurdle needing to be overcome. These officials refer to the problems as potential "show stoppers."

Essentially, the information system that DOD will use to verify beneficiary eligibility and enrollment has insufficient capacity to store the additional data that will be required under Coordinated Care. As a result, neither providers nor fiscal intermediaries (who pay claims) will have the information they need to determine or verify if a beneficiary is enrolled in Coordinated Care. This information is essential for (1) assessing whether a beneficiary is supposed to receive care through a military facility or CHAMPUS, (2) accurately applying beneficiary deductibles and copayments, and (3) paying provider claims.

I am sure you recall, Madam Chairman, that the extensive claims processing and payment problems experienced in the early days of CRI nearly led to the project's downfall. Several of the CAM projects also experienced claims payment problems. The potential for similar problems exists in Coordinated Care, and we continue to believe that DOD should address these problems before it begins delivering services under this approach. In other words, this lesson does not need to be relearned.

Project Evaluation and Measurement

Last fall, we reported that DOD was developing a system of performance indicators and measurements that it could use to assess the performance of its hospital commanders in managing the delivery of cost-effective, accessible, high-quality health care to beneficiaries. We questioned whether the performance measurement system being developed would serve as a suitable substitute for a comprehensive evaluation like that being conducted for the CRI and CAM projects. Additionally, in an October 1, 1991, memorandum, the Deputy Secretary of Defense instructed that a separate effort be undertaken to establish measures of performance by which to evaluate DOD's effectiveness in performing its medical mission and that these measures be submitted for his review.

We have been unable to obtain much information about either effort. As we understand it, both efforts are ongoing, and the Department is identifying, analyzing, and selecting various types of data to use as potential measures and standards of performance. DOD officials told us that they hope to have at least some of the details of the evaluation systems approved by this summer.

Budgeting and Resource Allocation

The Department's move to managed health care must include, or be accompanied by, a budgeting and resource allocation system that can accurately predict resource needs, distribute resources equitably, and give managers the proper incentives to achieve the desired health care and budgetary objectives. As we reported in October 1991, DOD's present system does not meet these criteria. Military hospital budgets are currently based on the workloads of various medical departments. This workload-driven budgeting system creates incentives, for example, to admit patients inappropriately and retain them longer than medically necessary in order to justify additional resources.

DOD acknowledges these shortcomings and intends to develop a new budgeting system over the next 5 years. This system, referred to as a capitation based methodology, will allocate resources on the basis of expected health care utilization for a defined group of individuals adjusted for such factors as gender, age, and health status. In this regard the Army, in fiscal year 1992, began testing a form of capitation budgeting for allocating medical care funds to 11 military service areas scheduled for initial implementation of Coordinated Care.

Also, last October, the Deputy Secretary of Defense gave the Assistant Secretary for Health Affairs the authority and responsibility for programming, budgeting, and allocating funds for all DOD medical activities, (except for medical personnel). However, since October, little progress has been made on this front. For example:

-- The fiscal year 1993 budget proposal was developed in essentially the same way as in the past, and Health Affairs has not worked out exactly how future budgets will be developed.

-- Funding needs for specific Coordinated Care projects, such as TRICARE in the Tidewater, Virginia, area--DOD's initial entry into Coordinated Care--still have not been identified.

-- The DOD Comptroller, while supporting the concept of Coordinated Care, expressed reservations about the support, basis, reasonableness, and accuracy of Health Affairs' projections of the program's costs and savings over the next decade.

DOD has a long way to go in developing the budgeting tools needed to manage the Coordinated Care program. Whether these tools and plans will be adequate to support and encourage the early implementation of Coordinated Care remains to be seen.

CONTRACTING FOR HEALTH CARE SERVICES

Another matter that is engendering much discussion and debate among those interested in military health care is the extent to which health care administration and delivery should be "contracted out"--or in other words, whether DOD should adopt the CRI model and contract for health care services or whether it should adopt the so-called "do-it-yourself" approach more analogous to the CAM projects. We concluded in our October 1991 report, and continue to believe, that neither approach should be used exclusively but rather both approaches should be blended. Let me explain.

DOD cannot meet all the health care needs of its beneficiaries solely through its own medical facilities, and it probably will become even less able to do so in the future as the size of the military medical corps is reduced as part of the overall downsizing of the military. Any medical corps reduction is bound to result in less in-house medical capability. However, this reduction may be proportionally more than overall workload reductions--particularly if a significant amount of the overall military downsizing is achieved through retirements. This is because retirees, their dependents, and survivors retain their eligibility for military health care. This likely scenario suggests to us a greater need for DOD to rely on contracting for health care services in the future.

DOD will need to decide how to allocate its medical personnel and where it makes the most economic sense to contract for services. In making these decisions, DOD should consider a number of factors, in addition to cost and quality of care considerations. These include

-- the availability of high-quality civilian health care providers in areas where beneficiaries are located,

-- military facilities' capabilities to deliver needed services,

-- wartime preparedness and training requirements, including arrangements to meet beneficiary needs during call-ups and deployments, and

-- the extent and variability of military expertise and continuity in administering managed health care programs.

These are difficult determinations, but they must be made for the military health care system to operate effectively.

CONCLUSIONS

Madam Chairman, in conclusion, I would like to reiterate our support for instituting managed care in the military health

services system and commend DOD for its initiative in getting this concept moving. While not a panacea, managed care does offer the potential for gaining more control over costs, improving beneficiary access, and offering high-quality care.

Many significant implementation obstacles remain. Overcoming them will require innovation, patience and, above all, compromise in order to reach consensus among widely differing views.

We believe the options we are presenting today for addressing the concerns about cost-sharing inequities and the proposed incentives for encouraging people to participate would improve the program from two standpoints. First, there would likely be a better chance of securing the necessary beneficiary support for the program if they were presented with a more equitable, less threatening, and more easily understood package of health care options to choose from. Second, program administration would be simplified and more consistent with prevailing managed care practices and health care benefit designs around the country.

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Madam Chairman, this concludes my prepared statement. We will be glad to answer any questions you or the other members of the Subcommittee may have.

Appendix I

Related GAO Products

Defense Health Care: CHAMPUS Mental Health Benefits Greater Than Those Under Other Health Plans (GAO/HRD-92-20, Nov. 7, 1991).

Defense Health Care: Implementing Coordinated Care--A Status Report (GAO/HRD-92-10, Oct. 3, 1991).

Defense Health Care: Health Promotion in DOD and the Challenges Ahead (GAO/HRD-91-75, June 4, 1991).

DOD's Management of Beneficiaries' Mental Health Care (GAO/T-HRD-91-30, May 15, 1991).

The Military Health Services System--Prospects for the Future (GAO/T-HRD-91-11, Mar. 14, 1991).

Defense Health Care: Potential for Savings by Treating CHAMPUS Patients in Military Hospitals (GAO/HRD-90-131, Sept. 7, 1990).

Potential Expansion of the CHAMPUS Reform Initiative (GAO/T-HRD-90-17, Mar. 15, 1990).

Implementation of the CHAMPUS Reform Initiative (GAO/T-HRD-89-25, June 5, 1989).

CHAMPUS Reform Initiatives: Unresolved Issues (GAO/T-HRD-87-4, Mar. 12, 1987).

Defense Health Care: CHAMPUS Reform Initiative: Unresolved Issues (GAO/HRD-87-65BR, Mar. 4, 1987).

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